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COMMENTARY

When Intensive Care is Perceived as a Place of Death: Family Decision Delay, Trust, and Financial Barriers to Timely Acceptance of ICU Admission in Somalia

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Abstract: This article is an evidence-informed commentary and conceptual reflection on delays in accepting intensive care unit (ICU) admission or escalation in Somalia, informed by contextual clinical experience and relevant literature rather than primary empirical measurement. In some families, ICU transfer may be interpreted not as a setting for advanced monitoring and potentially life-saving support, but as a sign that death is imminent. Such interpretations may be influenced by prior bereavement experiences, fear of separation from the patient, uncertainty about care quality and outcomes, financial barriers within a predominantly out-of-pocket system, and family-centered decision structures in which elders or household heads may authorize major care decisions. ICU services and workforce capacity have expanded gradually in urban Somali settings, including Mogadishu, yet public understanding of ICU purpose and processes may remain limited. We propose a context-informed conceptual pathway of ICU decision delay and outline a practical response framework emphasizing clear family explanation, structured communication and trust-building, respectful counseling of fear and grief, and feasible approaches to reduce immediate financial barriers at the point of escalation decisions to support timely acceptance of ICU admission or escalation when indicated.

Keywords: Somalia, intensive care unit, critical care, family decision making, treatment delay, health financing, trust, communication, low resource settings

Introduction

Critical illness care in fragile and conflict affected settings is often discussed in terms of infrastructure, oxygen, staffing, and equipment, yet the social pathway to ICU admission can be highly influential for timely access to life-saving care. In Somalia, emergency and critical care capacity has expanded gradually, but important gaps remain across hospitals and regions, including variation in service readiness and critical care resources.[1] This commentary focuses primarily on hospital-based critical care decision-making in urban Somali settings, where ICU services are more commonly available and escalation and payment decisions are frequently negotiated at the bedside; we recognize that experiences and pathways may differ across rural areas, facility types, adult versus pediatric populations, and referral versus non-referral contexts. In this paper, ICU decision delay refers to any clinically meaningful interval between a clinician's recommendation for ICU admission or escalation and the family's authorization and/or the patient's transfer, including delays related to family consultation, identification of a decision-maker, fundraising or deposit negotiation, and uncertainty about ICU purpose or prognosis. At the same time, healthcare financing in Somalia is heavily dependent on out of pocket spending, which creates immediate affordability barriers when urgent escalation is needed.[2]

Within this context, some families may interpret ICU referral through a lens of fear, prior loss, and uncertainty rather than through a biomedical understanding of time sensitive organ support. Observed patterns may include delayed

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consent, requests to wait, attempts to mobilize funds, consultation with family elders, or preference for home care despite clinical deterioration. This commentary addresses a neglected but highly actionable issue in Somali critical care pathways, namely family mediated ICU decision delay. The aim is to humanize and conceptualize this phenomenon in a way that is clinically useful, culturally respectful, and relevant to policy and hospital quality improvement. Similar patterns of family distress, communication needs, and decision-making challenges around critical illness have been described in other resource-variable ICU settings, supporting the relevance of a family-centered approach to escalation decisions.[3,4]

Contextualizing ICU Decision Delay in Somalia

In some Somali hospital settings, ICU admission may be symbolically associated with death because families may remember episodes in which severely ill relatives died after ICU transfer; however, such outcomes are often confounded by illness severity at the time of referral, and poor outcomes may reflect late escalation and advanced critical illness rather than ICU transfer itself.

This produces a powerful community memory in which ICU becomes the final place a patient is taken rather than a place where reversible deterioration may be treated. Such perceptions are not unique to Somalia because family beliefs and attitudes toward ICU care are shaped by culture, religion, prior experiences, and trust in institutions across settings.[3,4] However, in Somalia these perceptions may be intensified by fragile health system history, uneven quality across facilities, and delayed development of formal critical care services.[1] These experiences are likely to vary by region, facility type, educational background, and family structure, and the patterns described here should be interpreted as context-informed and plausible rather than universally uniform.

Family distress is also amplified by the experience of separation. Across many Somali households, close physical and emotional presence with a sick relative is commonly valued, and restricted access may be experienced as abandonment or moral failure, and caregivers who assume primary bedside roles may experience guilt, anxiety, or fear of social judgment when they cannot remain near the patient. International critical care literature from other settings suggests that family members of critically ill patients often need frequent information, reassurance, and structured communication, and that unmet psychosocial needs may worsen distress; however, these findings provide supportive guidance rather than Somalia-specific evidence, and the patterns described here require local empirical validation.[5,6] In low resource settings, these needs may be even more pronounced because uncertainty is compounded by resource limitations and financial pressure.[6]

Financial barriers are central to ICU delay in Somalia. In a system with high out of pocket expenditure and minimal insurance coverage, the recommendation for ICU transfer can trigger immediate financial shock at the bedside.[2]

Families may delay decisions while seeking money from relatives, negotiating deposits, purchasing medications externally, or weighing catastrophic spending against uncertain outcomes. In practice, the decision is often not only medical but also economic and collective, with authority concentrated in a family head or elder rather than the individual present at the bedside. Decision authority structures vary across families and settings, and should not be assumed to rest with a single household member in all cases. Delays may range from brief postponement for consultation or fundraising to prolonged deferral and de facto refusal of escalation. This decision structure can prolong the interval between clinician recommendation and treatment initiation, particularly when communication is fragmented or when urgency is not explained clearly in plain Somali. Delays may range from brief postponement for consultation or fundraising to prolonged deferral and de facto refusal of escalation.

Conceptual Model and Practice Framework

We propose a context-informed conceptual model, informed by contextual clinical observation and relevant literature, to map how ICU decision delay may unfold in Somali hospitals, from clinician recognition of critical illness to poor outcomes or perceived poor outcomes. The model begins when a clinician identifies critical illness and recommends ICU admission or escalation. It then passes through a family interpretation and decision phase, where fear, prior bereavement experiences, mistrust, financial shock, and need for elder approval shape meaning and action. This may progress into delay behaviors such as requests to observe first, home care preference, alternative treatment seeking, delayed consent during fundraising, and refusal or deferral of ICU transfer. The downstream effect is time sensitive deterioration, with loss of the early ICU benefit window, clinical worsening before transfer, and higher complication or mortality risk.

Figure 1 presents a conceptual pathway linking clinician recommended intensive care escalation to a family interpretation and decision phase shaped by fear, bereavement memory, distrust, financial shock, and family authority structures. The model illustrates how these factors may lead to delay behaviors that increase the risk of deterioration before transfer and subsequently reinforce community beliefs when outcomes are poor or perceived as poor. The operational implications of this pathway and corresponding responses at clinical, hospital, and policy levels are further organized in Table 1.

To support practical implementation, this commentary proposes a four component framework centered on clarification, connection, counseling, and cushioning. Clarification refers to clear explanation of intensive care purpose and urgency in plain Somali. Connection refers to structured family updates and meaningful inclusion in communication. Counseling refers to respectful engagement with fear, grief memories, trust concerns, and religious concerns. Cushioning refers to practical measures that reduce immediate financial barriers to time sensitive transfer. This framework is intentionally pragmatic and adaptable to resource constraints while remaining aligned with broader family centered critical care principles.[4,6]

Implications for Clinical Practice and Health Policy

Improving timely acceptance of ICU admission or escalation in Somalia may require a dual strategy that combines continued expansion of critical care capacity with social and communication interventions that reduce delay in acceptance. At the clinical level, explanation of intensive care may be immediate, clear, and compassionate, using plain Somali language and explicitly addressing what the intensive care unit is intended to provide, what risks are associated with delay, and how the family will continue to receive updates. Practical barriers and corresponding mitigation strategies that may be adopted at hospital and policy level are summarized in Table 1, and are supported by family-centered critical care guidance.[4,5]

At the hospital level, practical low-cost measures may improve intensive care decision processes. These include structured communication scripts, designated family liaison roles, scheduled update times, and visible Somali-language materials explaining what families can expect when a patient is transferred to intensive care. Such approaches align with family-centered critical care principles and may reduce confusion, fear, and conflict during high-stress decisions.[4–7]

At the policy level, reducing financial barriers to time-sensitive escalation may require both near-term facility actions and longer-term health financing reforms. In the near term, hospitals and health authorities may consider mechanisms that allow emergency stabilization before full payment where feasible, flexible deposits, emergency support pathways, and social welfare or charitable referral processes for high-risk families. Over the longer term, reforms that reduce out-of-pocket burden through risk pooling and insurance expansion are complex but likely important for improving timely access and may improve outcomes in emergency and critical care.[1,2]

Community and religious engagement may also warrant priority. Public messaging that frames treatment seeking as compatible with faith may reduce moral distress and hesitation among families who fear that accepting intensive care implies abandoning religious trust. In the Somali context, a potentially helpful framing may be that families use available means of care while entrusting outcomes to Allah. Such messages may be communicated with humility and developed in partnership with trusted local religious and community leaders, rather than presented as prescriptive theological guidance. This approach is culturally respectful and may support timely acceptance of ICU admission or escalation when clinically indicated.

Because this is a commentary, these proposals are presented as context-informed and feasible suggestions, and their effectiveness should be evaluated in Somali settings.

Research Agenda

The observations described in this commentary should be tested and refined through empirical research in Somali settings. Priority work includes qualitative interviews with families who accepted promptly, accepted after delay (including postponement for consultation or fundraising), or declined/de facto refused intensive care transfer, hospital audits assessing time from ICU recommendation to family authorization and transfer, and mixed-methods studies that measure specific financial delay components, including time required for fundraising, negotiation over deposits, out-of-pocket purchase of medications, and

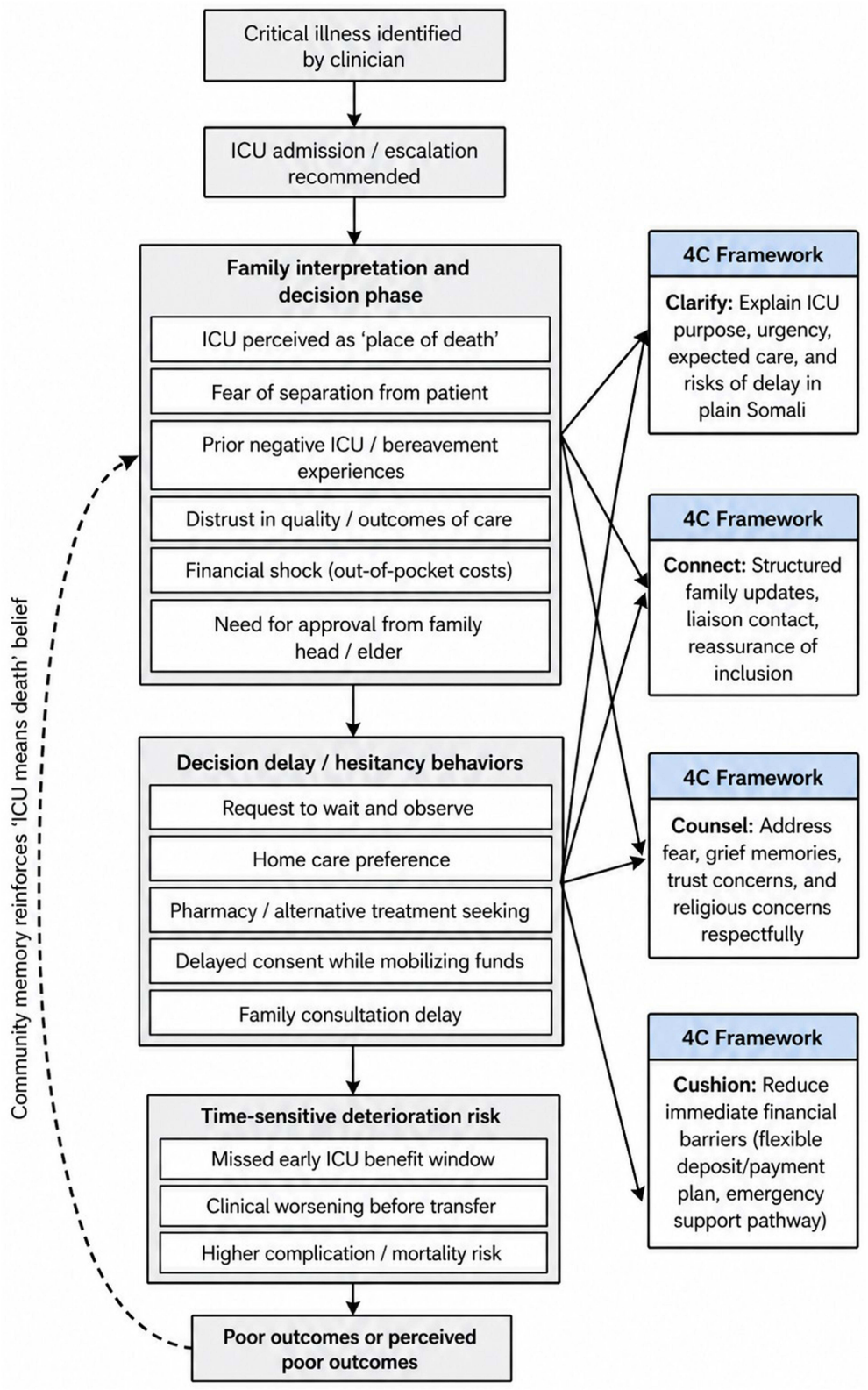

Figure 1 Pathway of ICU Decision Delay in Somalia and Intervention Points (Conceptual Model). This figure shows how family beliefs, fear, prior loss, distrust, financial shock, and family authority structures may delay clinician recommended ICU transfer in Somalia, worsen pre transfer deterioration, and reinforce future delay, while highlighting intervention points based on clarification, connection, counseling, and cushioning.

Table 1 Key Drivers of ICU Delay or Hesitancy in Somalia and Pragmatic Mitigation Strategies

Key Driver	How It May Contribute to ICU Delay	Pragmatic Mitigation Strategies (Aligned to 4C Framework: Clarification, Connection, Counseling, Cushioning)	Health Policy and Systems Implications
ICU perceived as a place of death	Families may associate ICU transfer with inevitable death and defer consent until severe deterioration occurs	Clarify: Use a brief Somali-language ICU explanation script at the time of recommendation; explain ICU purpose and the risks of delay. Connect: Provide repeated updates rather than a single one-time discussion.	Public awareness messaging on the role of ICU in life saving care and early escalation
Fear of separation from patient and perceived neglect	ICU restrictions may be interpreted as abandonment, exclusion, or loss of moral duty to remain near the patient	Connect: Structured family communication; designated family liaison contact; scheduled update times. Clarify: Clearly explain visitation procedures where feasible and how families will remain included in communication.	Development of family centered ICU communication standards in hospitals
Prior bereavement or negative ICU experiences	Past poor outcomes may reinforce fear and mistrust and lead to delayed decision making in future cases	Counsel: Acknowledge prior experiences respectfully. Clarify: Provide a realistic but compassionate explanation of current prognosis and treatment goals.	Community trust building and continuity in quality improvement across facilities
Distrust in quality or outcomes of care	Families may doubt whether ICU provides meaningful benefit compared with cost	Connect: Consistent team messaging and improved communication documentation. Clarify: Transparent explanation of expected care and limitations.	Quality assurance systems and public trust strengthening initiatives
Financial shock from out of pocket costs	Families may delay transfer while mobilizing funds, negotiate payment, or choose lower cost alternatives	Cushion: Flexible deposit options where possible; social support referral; emergency financial pathways. Clarify: Early cost counseling at the point of escalation decisions.	Financial protection mechanisms, emergency care funding support, risk pooling, and insurance expansion
Need for approval from family head or elder	Decision authority may rest with absent or distant family decision maker, delaying urgent consent	Connect: Identify the key decision-maker early and hold a rapid family conference. Clarify: Use an urgent escalation script that explains time sensitivity.	Context sensitive emergency consent guidance and hospital escalation protocols
Limited public understanding of ICU care	ICU may be viewed as unfamiliar, invasive, or only for dying patients	Clarify: Somali-language visual materials and short orientation messages in emergency and ward settings.	Community education through health facilities, media, and trusted leaders
Religious and moral concerns about end of life and treatment seeking	Families may experience distress about whether ICU care conflicts with faith or acceptance of fate	Counsel: Respectful counseling that treatment seeking and trust in Allah are compatible. Connect: Involve trusted religious voices where appropriate.	Faith sensitive public communication and partnership with religious leaders

Abbreviation: ICU, intensive care unit.

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waiting for family authorization, alongside implementation studies evaluating structured communication tools. Generating local evidence will strengthen policy design, improve contextual validity, and help move this area from recurrent frontline observation to measurable quality improvement.

Conclusion

In Somalia, delayed acceptance of intensive care is not only a problem of equipment, beds, or staffing. It is also a problem of meaning, trust, family distress, and affordability at the point of critical illness. Families who hesitate are often responding to grief memories, social obligations, and financial risk under uncertainty. This commentary adds by reconceptualizing ICU decision delay as a modifiable social, relational, and economic process at the point of escalation decisions and by proposing a practical framework to address it. Strengthening critical care outcomes in Somalia will therefore require integrated strategies that combine infrastructure and workforce development with culturally grounded communication, family centered engagement, and financial protection mechanisms.

Abbreviation

ICU, intensive care unit.

Data Sharing Statement

No new datasets were generated or analyzed in this study.

Ethics Approval and Informed Consent

Ethics approval and informed consent were not required for this commentary because it did not involve primary data collection, human participant recruitment, intervention, or identifiable patient information. The article is based on contextual analysis and practice-informed commentary.

Consent for Publication

Not applicable because no identifiable personal or patient information is included in this manuscript.

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Author Contributions

All authors made a significant contribution to the work reported, whether in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising, or critically reviewing the article; gave final approval of the version to be published; agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

Disclosure

The authors report no conflicts of interest in this work.

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